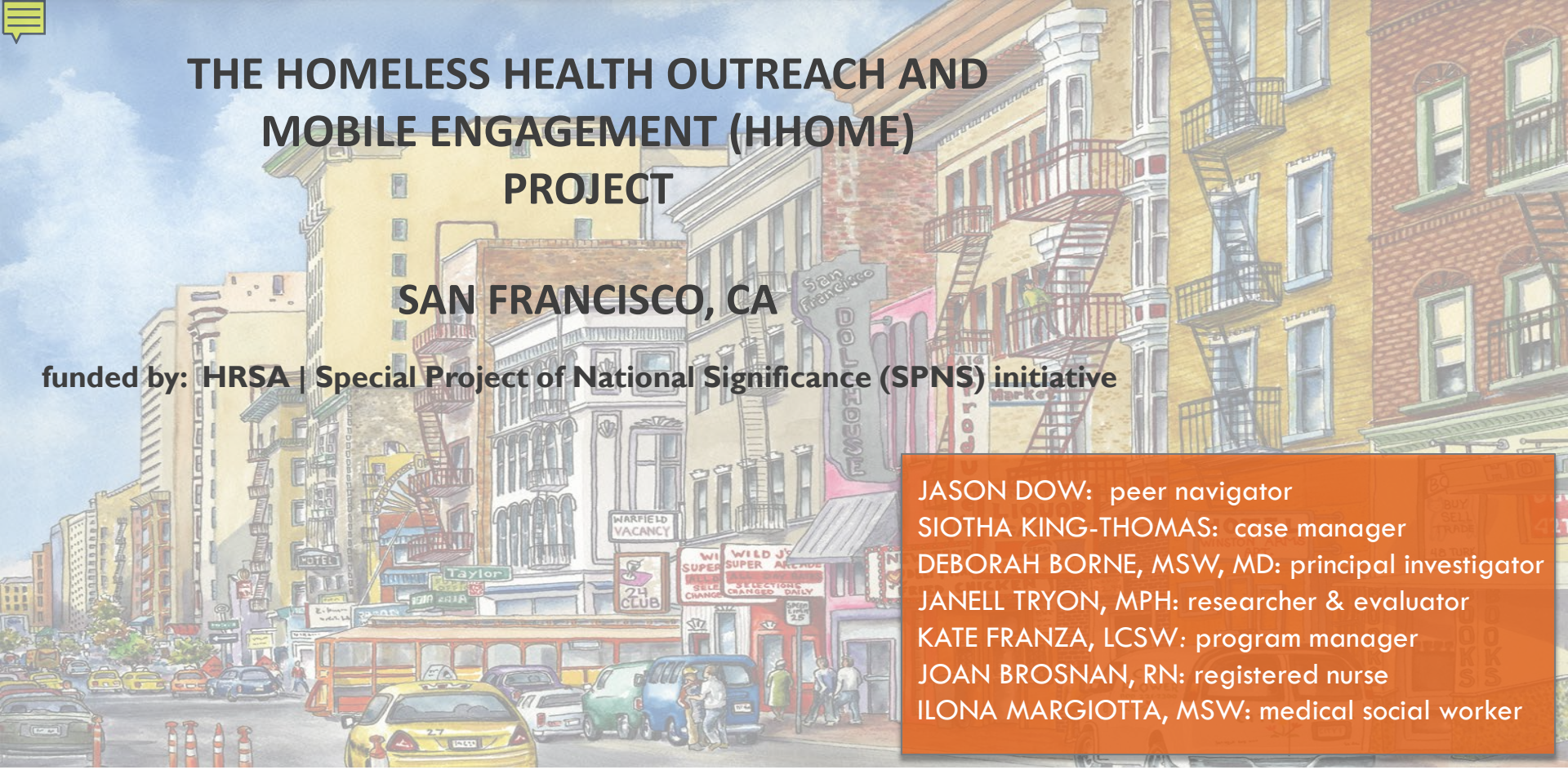
THE HOMELESS HEALTH OUTREACH AND MOBILE ENGAGEMENT (HHOME) PROJECT

SAN FRANCISCO, CA

funded by: HRSA | Special Project of National Significance (SPNS) initiative



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San Francisco
Department of Public Health

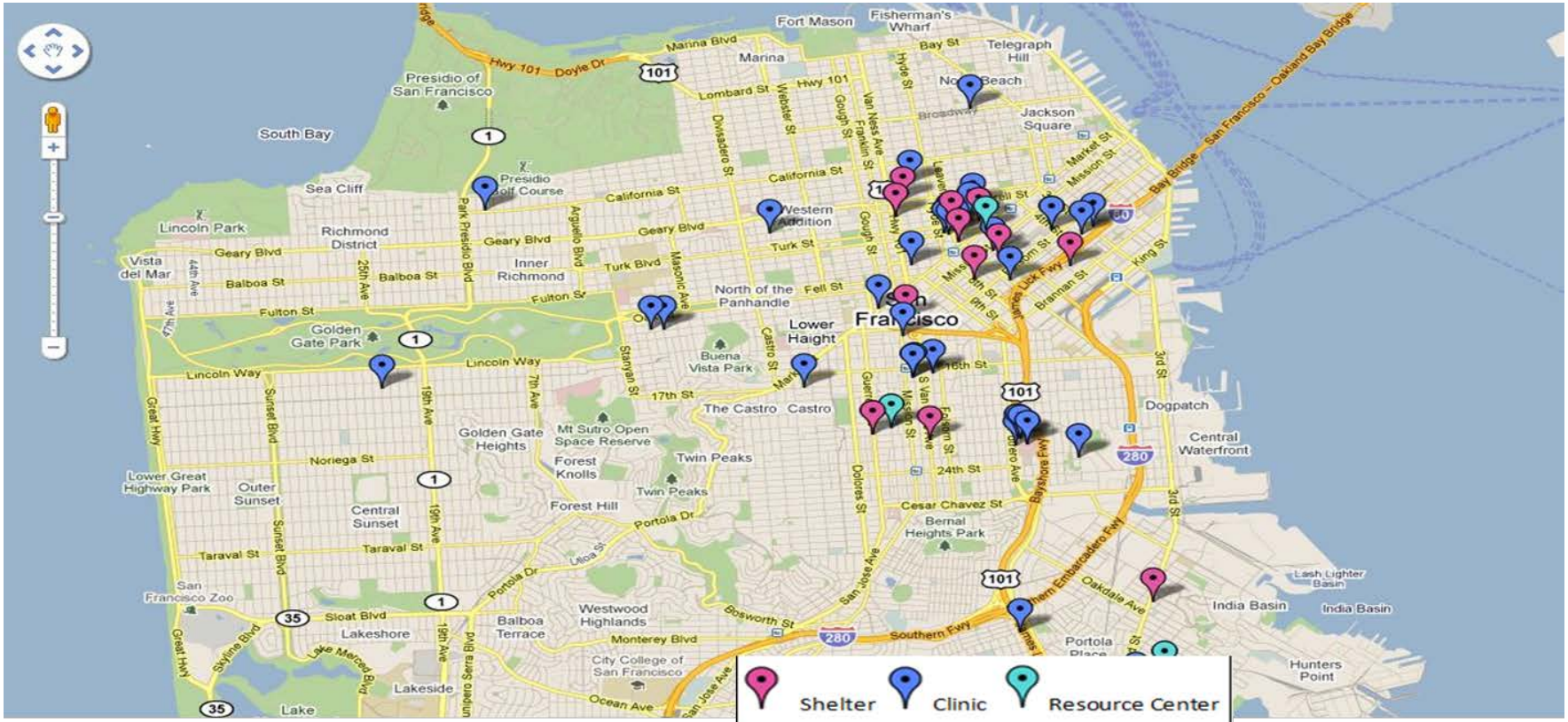
ASIAN & PACIFIC ISLANDER
WELLNESS CENTER

AGENDA

- THE LANDSCAPE
- A SNAPSHOT of HOMELESSNESS in SF
- MEET the TEAM
- STAKEHOLDERS
- DEMOGRAPHICS
- REFERRALS & COMMUNICATION
- MOBILE CARE
- TRANSITIONS
- OUTCOMES

SF Department of Public Health:

MEDICAL CLINICS, CONSORTIUM CLINICS, & SHELTERS



HOMELESSNESS in SF

Average age of death for someone Experiencing Homelessness: **43 years**

70 % have a Chronic Illness:
Medical or Behavioral Health Issue

2015 Homeless Count people who are chronically homeless:

- 55% Mental Health Condition
- 35% Post Traumatic Stress Disorder
- 62% Have Substance Abuse
- 43% Chronic Health Problems

Data from HUD Funded San Francisco Homeless Count – 2009/2011/2015

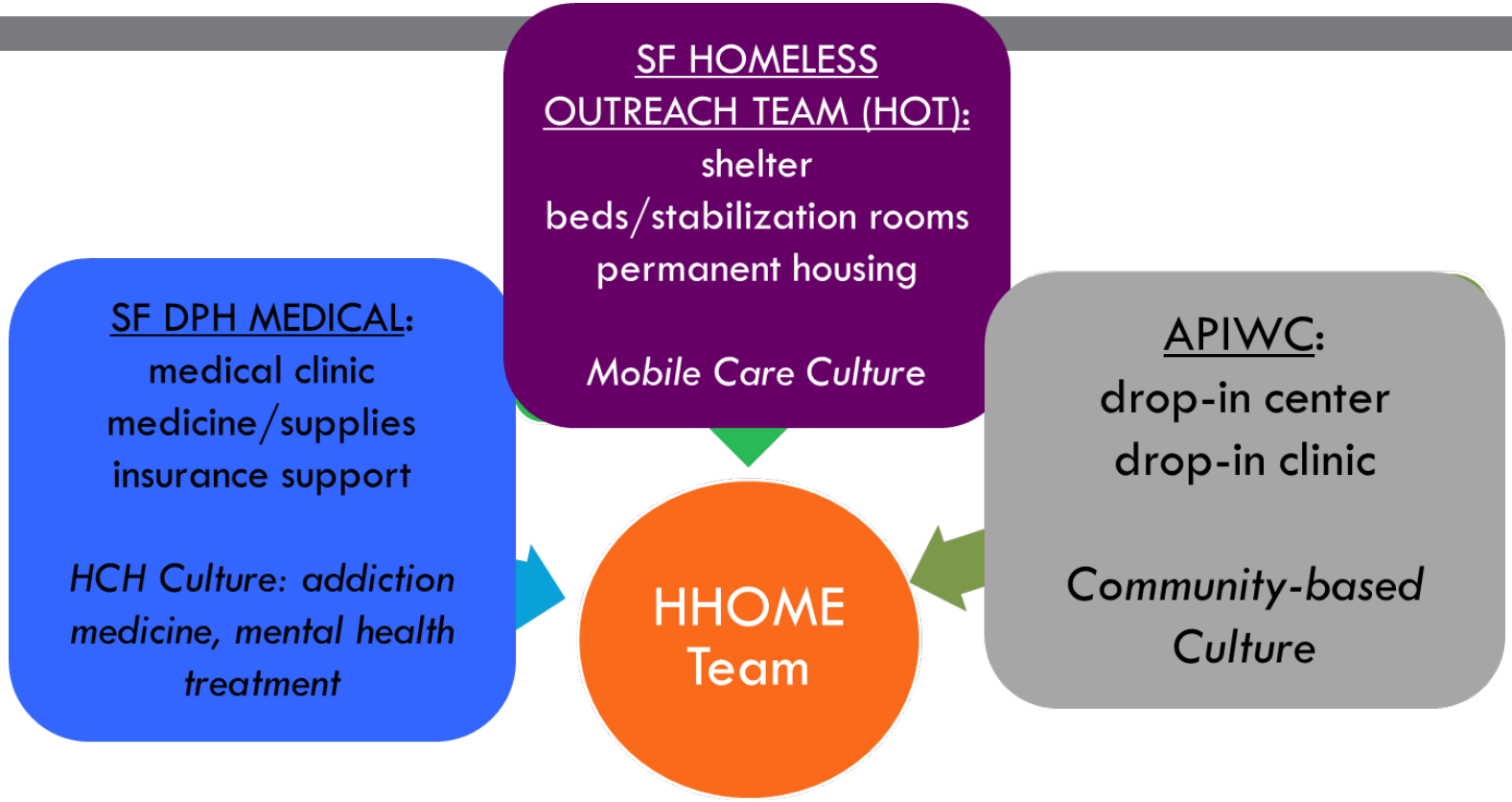
DPH FY 2014-2015:

DATA for CLIENTS EXPERIENCING HOMELESSNESS

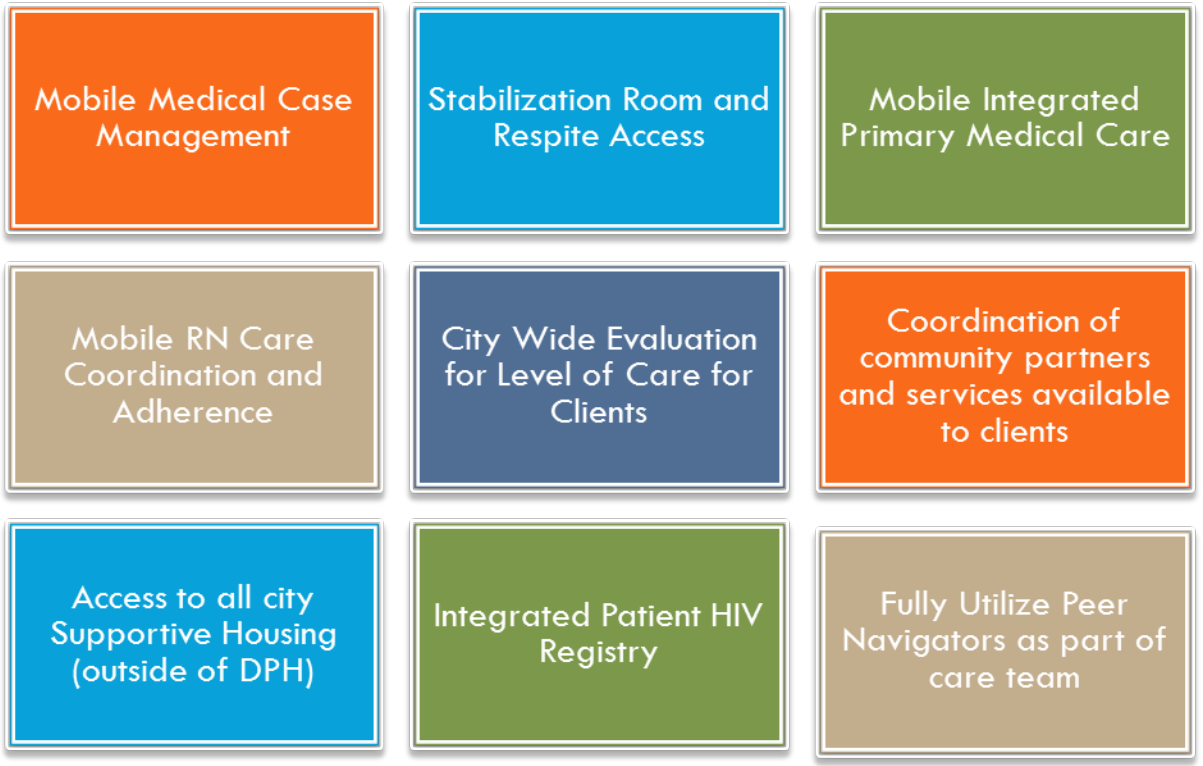
	HOMELESS	HOMELESS > 10 YEARS	TAY 18-24	WOMEN	AGE 60+	TOP 1-5% HIGH UTILIZERS
Total Number	9,975	3,272	631	2,403	1,304	1,234
% HIV	7.5% (747)	12.3%	2.7%	5.3%	6.6%	13.3% (173)

Coordinated Case Management System (CCMS) Homeless Client Data

HHOME Team

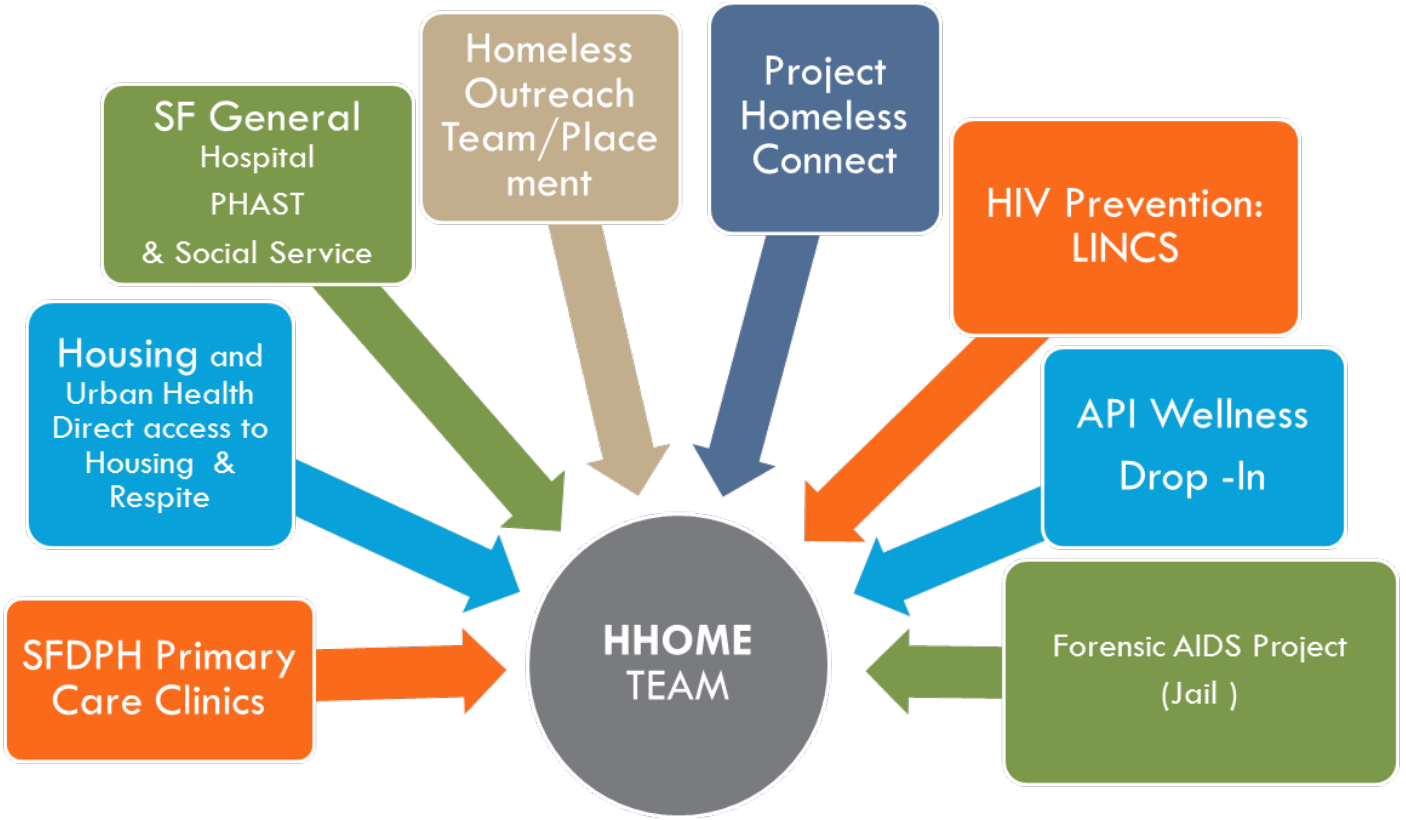

SF HOMELESS OUTREACH TEAM (HOT):
shelter
beds/stabilization rooms
permanent housing
Mobile Care Culture
SF DPH MEDICAL:
medical clinic
medicine/supplies
insurance support
HCH Culture: addiction medicine, mental health treatment
HHOME Team
APIWC:
drop-in center
drop-in clinic
Community-based Culture

INTEGRATED MOBILE CARE:
a citywide collaboration



SPNS-grant/HHOME offered a sustainable way to take on an already burgeoning project

HHOME PARTNERS & STAKEHOLDERS

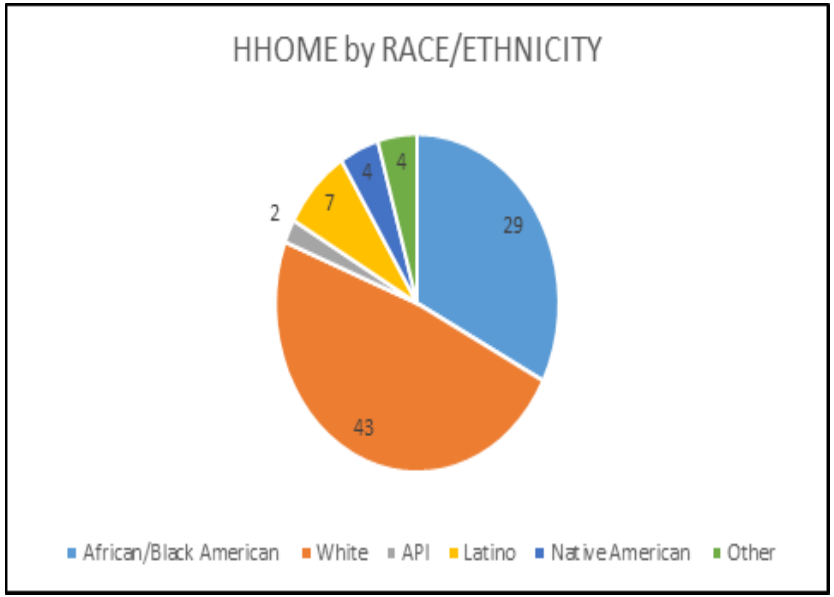


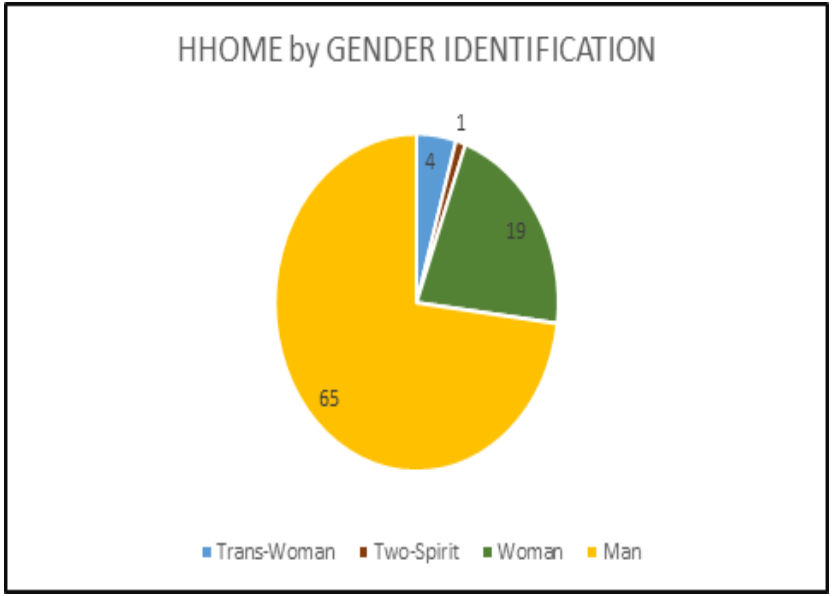
HHOME: targeting the hardest-to-reach

to be considered for enrollment, a client must be:

- **living with HIV**
- experiencing **active substance use**
- **not adherent** to or prescribed HIV Medicine
- **living with mental illness**
- **living on the street** or in HRSA-defined unstable housing
- **not currently engaged** in primary medical care

DEMOGRAPHICS





PARTICIPATION | ENROLLMENT

- CLIENTS **SERVED: 90** in 2 years
- **ENROLLED** in STUDY: **61** participants
- **ACTIVE** PANEL:
  - **40** For team with 0.2 FTE MD
  - **20** per CM
- **REFERRED**: ~ **130** clients

REFERRALS

HOSPITAL

MEDICAL

PSYCHIATRIC

EMERGENCY ROOM

SHORT-TERM/LONG-TERM CARE

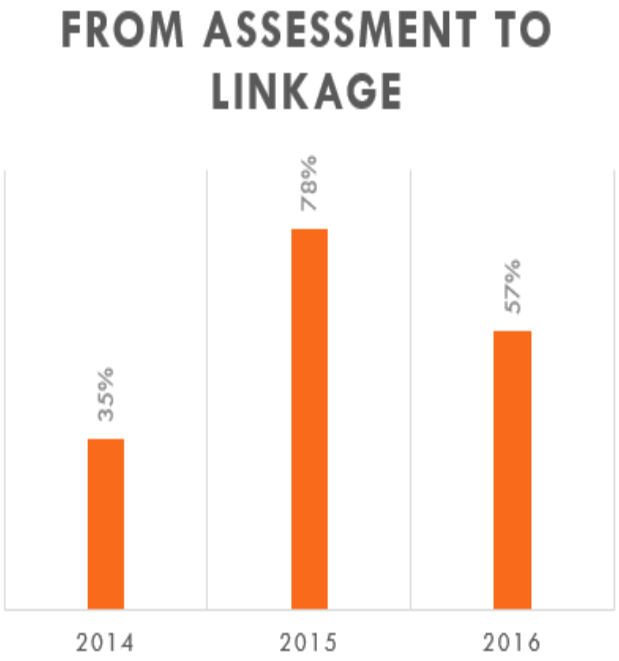
COMMUNITY

PRIMARY CARE

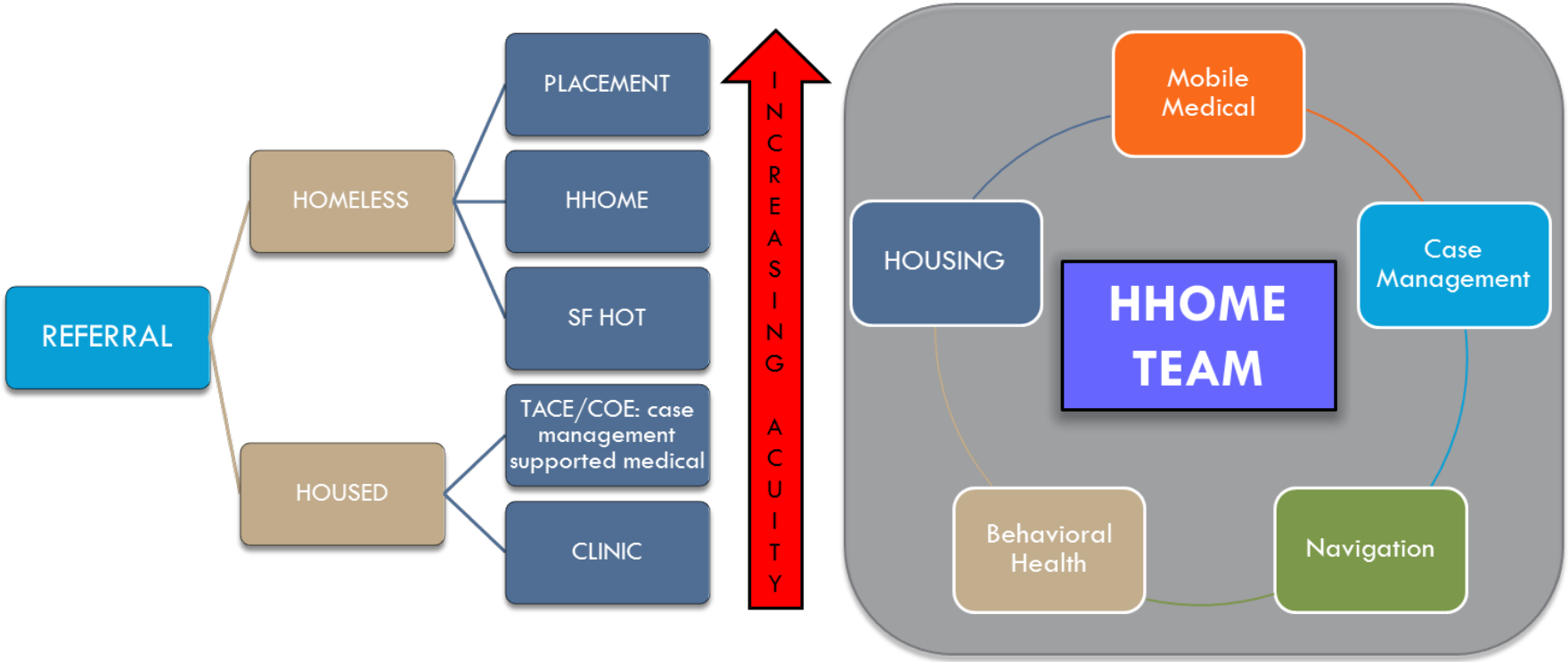
URGENT CARE

POLICE/JAIL

SHELTER/STREET OUTREACH



ACUITY and **CHRONICITY ASSESSMENT** for **REFERRALS**



MOBILE PRIMARY CARE: opportunity to cross-train

PRIMARY CARE
with MD & MEDICAL SOCIAL WORKER

1. Outreaching
   CBOs/Streets/Encampments
2. Visiting **Hospital/Shelter/SRO**
3. **Co-located Clinics**

- HIGHEST ACUITY CLIENTS
- ROUTINE CLINICAL CHECK
- MEDICAL COUNSELING

NURSING & MEDICATION ADHERENCE
with RN, Peer, and CM

1. Outreaching
   CBOs/Streets/Encampments
2. Visiting **Hospital/Shelter/SRO**
3. **Co-located Clinics**

- LOWER ACUITY CLIENTS
- MEDICATION ADHERENCE for ALL CLIENTS
- ROUTINE NURSING CHECK

MOBILE HOUSING CASE MANAGEMENT

HOUSING STATUS DEPENDS on:

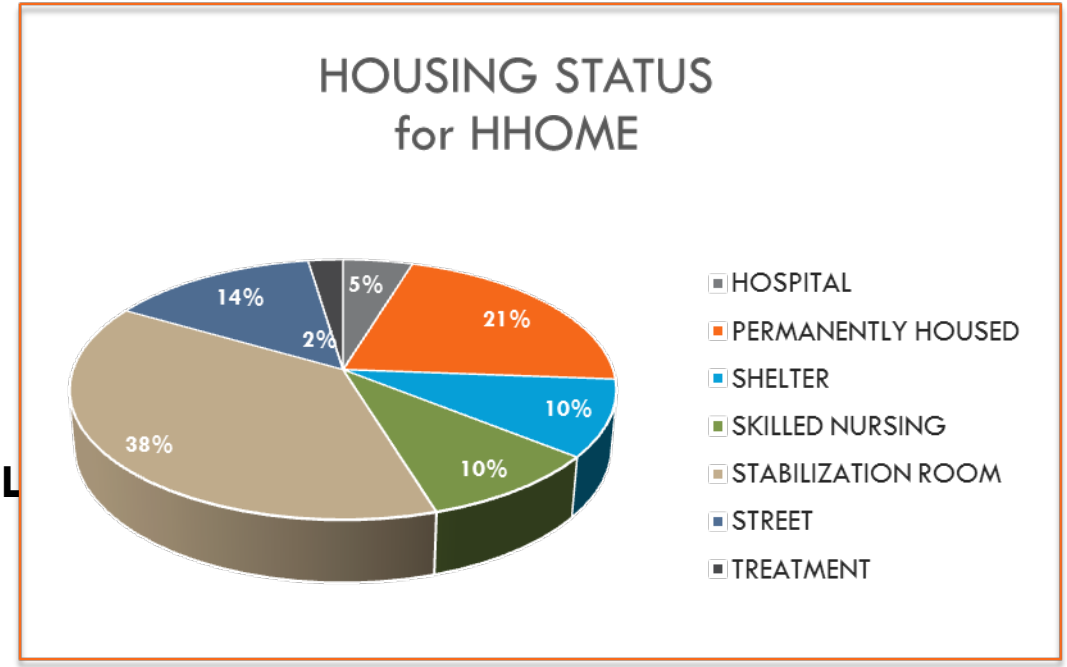
- Readiness of client

AND

- Housing availability (crisis in SF)

IT'S ALL ABOUT APPROPRIATE LEVEL

- skilled nursing facility (SNF)
- emergency shelter
- treatment/detox
- street*



WHY MOBILE VISITS

MOBILE CARE

during this time it is crucial that the entire team be available to provide mobile care in the community

EVEN/ESPECIALLY WHEN CLIENTS ARE HOUSED…

clients struggle with being indoors, organization, and creating new routine; most often this “housing” includes temporary, emergency rooms

MOBILE PEER NAVIGATION

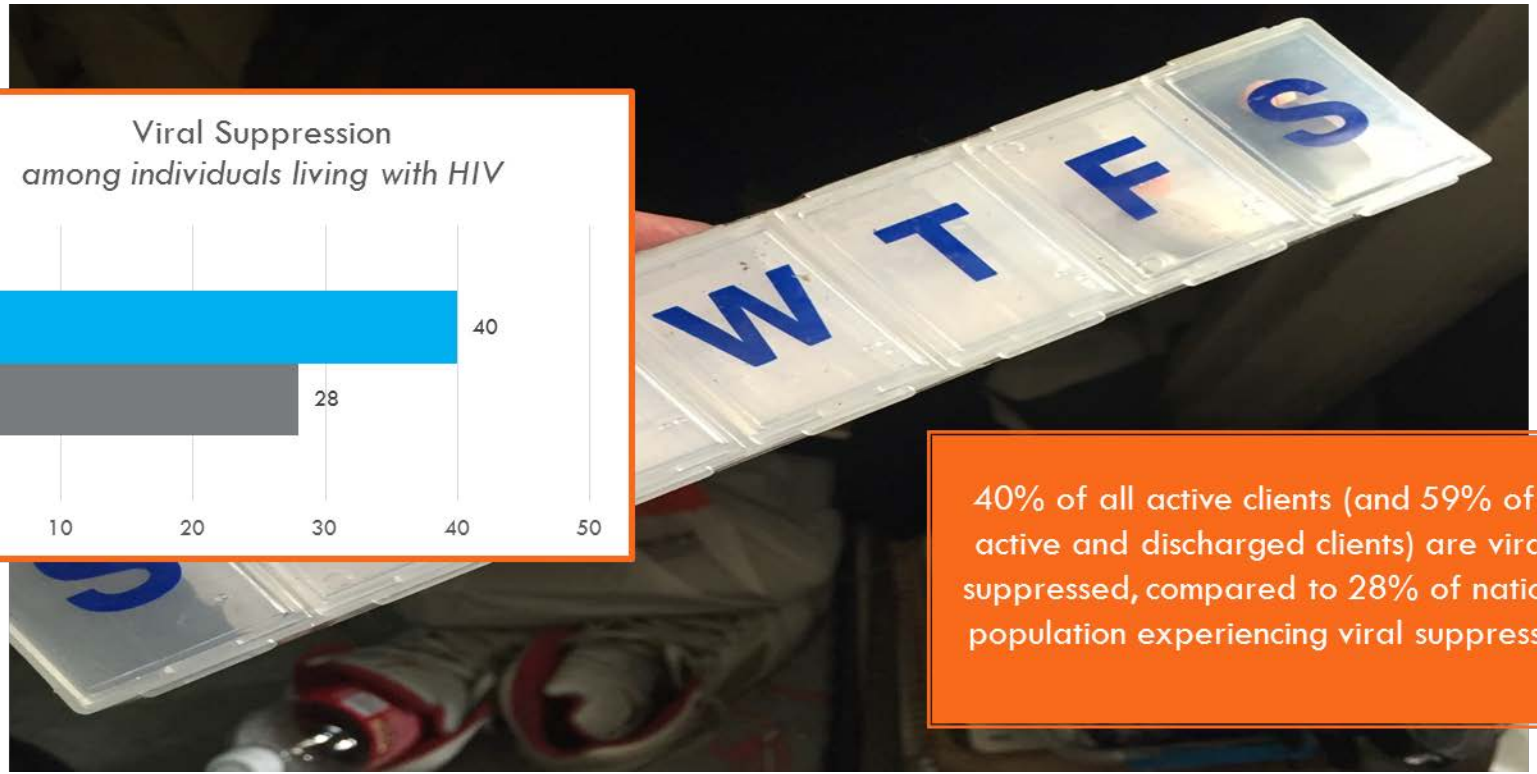
relationship building

1. Build **RELATIONSHIPS** and **TRUST**
2. Find out their "hot spots"
3. Learn their substance use history

the ins & outs of navigation

- escort clients to appointments
  - **Social security**
  - **GA**
  - **Medi-Cal**
  - **Clinical appointments**
  - **DMV**
  - **And so on!**
- search and find clients (call hospitals and jails; search the city on foot)
- Be the first line of contact with new clients

CLINICAL OUTCOMES



40% of all active clients (and 59% of all active and discharged clients) are virally suppressed, compared to 28% of national population experiencing viral suppression

SUCCESSES | CHALLENGES

- Trauma-informed Care
- Client-centered and System-supported
- Cross-training of team
- Starting treatment anywhere, anytime
- Team Communication
- Community pharmacy
- Support of Lead Agencies
- Courage of consumer and team

- Not Enough Stabilization or Supportive Housing
- Not enough Navigation or RN time
- Lack of Trauma Informed Programs and Providers
- Lack of communication between hospital and community